



NTSB National Transportation Safety Board

Improvement Through Collaboration: Aviation Industry Success Story

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The Contrast

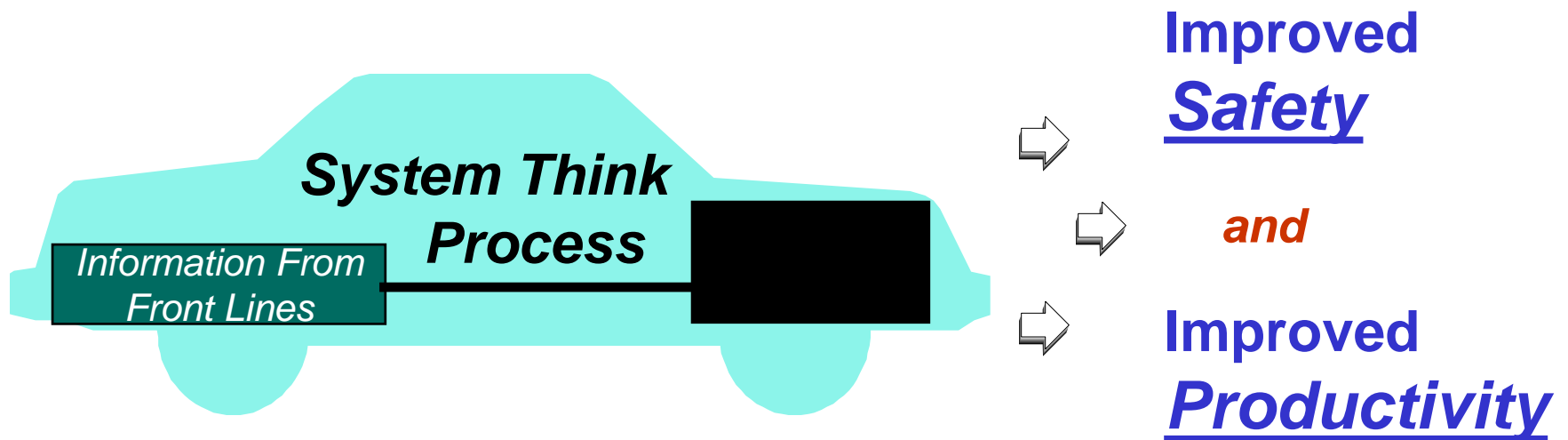
- Conventional wisdom:

Improvements that reduce risk usually
also reduce productivity

- Lesson learned from
proactive aviation safety programs:

Risk can be reduced in a way that also results in
immediate productivity improvements

Process Plus Fuel Creates a Win-Win



Outline

- **The Context**
- **Importance of “System Think”**
- **Importance of Better Information**
- **Improved Safety *and* Productivity**
- **Roles of Leadership and Regulator**
- **Success Story is Transferable**

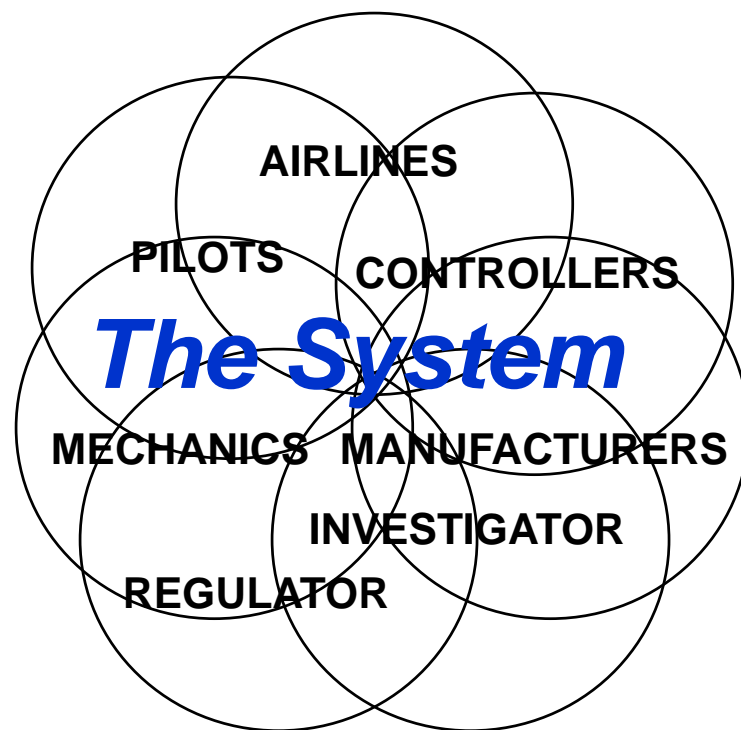
NTSB 101

- Independent federal agency, investigate transportation mishaps, all modes
- Determine probable cause(s) and make recommendations to prevent recurrences
- Primary product: Safety recommendations
 - Favorable response > 80%
- ***SINGLE FOCUS IS SAFETY***
- Independence
 - Political: Findings and recommendations based upon evidence rather than politics
 - Functional: No “dog in the fight”



The Context: Increasing Complexity

- More system *interdependencies*
 - Large, complex, interactive system
 - Often tightly coupled
 - Hi-tech components
 - Continuous innovation
 - Ongoing evolution
- Safety issues are more likely to involve *interactions between parts of the system*



Effects of Increasing Complexity:

More “human error” because

- **System more likely to be error prone**
- **Operators more likely to encounter unanticipated situations**
- **Operators more likely to encounter situations in which “By the Book” may not be optimal (“workarounds”)**

The Result:

Front-line staff who are

- Highly trained
- Competent
- Experienced,
- Trying to do the right thing, and
- Proud of doing it well

. . . yet they still commit

**Inadvertent
human errors**

The Solution: System Think

***Understanding how a
change in one subsystem
of a complex system may
affect other subsystems
within that system***

“System Think” via Collaboration

Bringing all parts of a complex system together to collaboratively

- **Identify potential issues**
- ***PRIORITIZE* the issues**
- **Develop solutions for the prioritized issues**
- **Evaluate whether the solutions are**
 - **Accomplishing the desired result, and**
 - **Not creating unintended consequences**



When Things Go Wrong

How It Is Now . . .

You are highly trained

and

If you did as trained, you
would not make mistakes

so

You weren't careful
enough

so

You should be **PUNISHED!**

How It Should Be . . .

You are human

and

Humans make mistakes

so

Let's *also* explore why the
system allowed, or failed to
accommodate, your mistake

and

Let's **IMPROVE THE SYSTEM!**

Fix the Person or the System?

Is the **person**
clumsy?

Or is the
problem . . .

The *step*???



Enhance Understanding of Person/System Interactions By:

- Collecting,**
 - Analyzing, and**
 - Sharing**
- # **Information**

Objectives:

Make the System

***(a) Less
error prone***

and

***(b) More
error tolerant***

The Health Care Industry

To Err Is Human:

Building a Safer Health System

“The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system.”

Institute of Medicine, Committee on Quality of Health Care in America, 1999

Major Source of Information: Hands-On “Front-Line” Employees

**“We knew about
that problem”**

***(and we knew it might hurt
someone sooner or later)***

Next Challenge



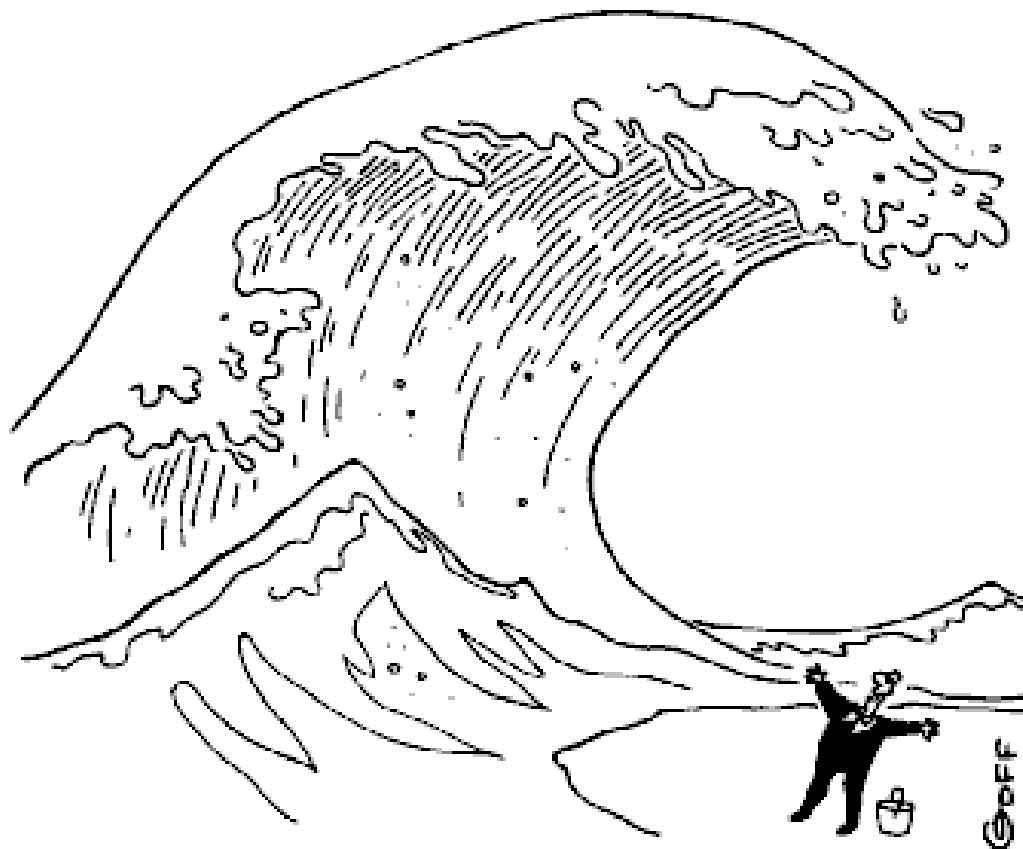
Legal/Cultural Issues

Improved Analytical Tools

As we begin to get over the first hurdle, we must start working on the next one . . .

Information Overload

© 1996 Ted Goff



"EUREKA! MORE INFORMATION!"

From Data to Information

Tools and processes to convert large quantities of data into useful information

Data Sources

Info from front line staff and other sources

DATA



Analysts

USEFUL

INFORMATION

Smart Decisions

- Identify issues
- **PRIORITIZE!!!**
- Develop solutions
- Evaluate interventions

Tools

Processes



Aviation Success Story

83% decrease in fatal accident rate,
1998 - 2007

largely because of
System Think

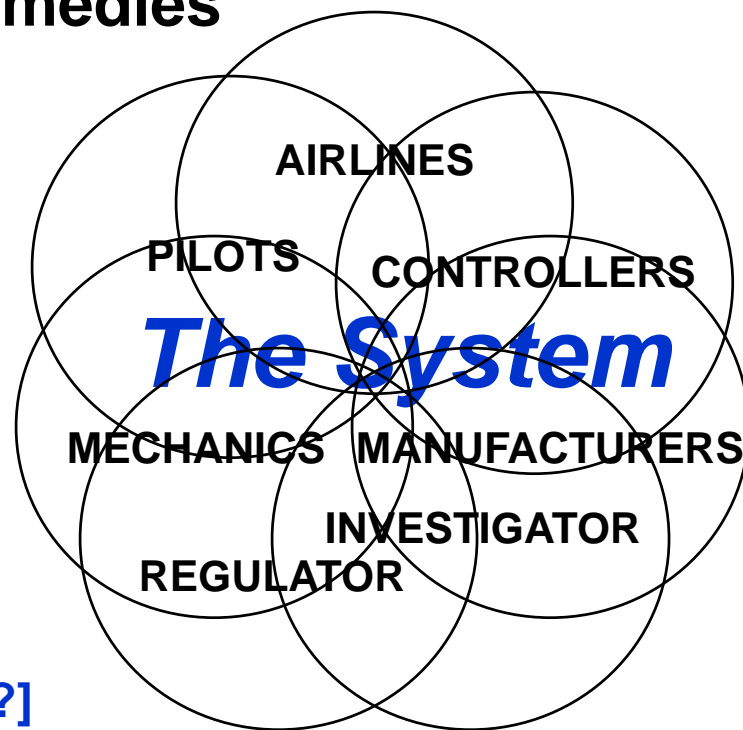
fueled by
***proactive safety
information programs***

P.S. Aviation was already considered **VERY SAFE** in 1997!!

Aviation “System Think” Success

Engage all participants in identifying problems and developing and evaluating remedies

- Airlines
- Manufacturers
 - *With the systemwide effort*
 - *With their own end users*
- Air Traffic Organizations
- Labor
 - *Pilots*
 - *Mechanics*
 - *Air traffic controllers*
- Regulator(s) **[Query: Investigator(s)?]**



Moral of the Story

Anyone who is
involved in the *problem*
should be
involved in the *solution*

Major Paradigm Shift

- **Old: The regulator identifies a problem, develops solutions**
 - Industry skeptical of regulator's understanding of the problem
 - Industry fights regulator's solution and/or implements it begrudgingly

- **New: Collaborative “System Think”**
 - Industry involved in identifying problem
 - Industry “buy-in” re interventions because everyone had input, everyone's interests considered
 - Prompt and willing implementation
 - Interventions evaluated . . . *and tweaked as needed*
 - Solutions probably more effective and efficient
 - Unintended consequences much less likely

Challenges of Collaboration

- Human nature: “I’m doing great . . . *the problem is everyone else*”
- Participants may have competing interests, e.g.,
 - Labor/management issues
 - May be potential co-defendants
- Regulator probably not welcome
- Not a democracy
 - Regulator must regulate
- Requires all to be willing, *in their enlightened self-interest*, to leave their “comfort zone” and think of the System

Applicability of Collaborative Approach:

- Entire industry**
- Company (Some or All)**
- Type of activity**
- Facility**
- Team**
- Workplace safety**

Workplace Safety Beta Test

- Select troublesome area**
 - Nagging problem for many years
 - Many interventions have been tried, not successful
 - Likelihood that problems are systemic, not just people
 - Collaboration as effort to address the system problems
 - Less defensiveness because not focused on single event

- Select collaborative corrective action group**
 - All who have a hand in the process
 - Manufacturers?
 - Operators?
 - Regulators?
 - Others?



Note HRO Characteristics*

- Preoccupation with failure**
- Reluctance to simplify interpretations**
- Sensitivity to operations**
- Commitment to resilience**
- Deference to expertise**

***Source: Weick and Sutcliffe**

The Role of Leadership

- Demonstrate safety commitment . . .
but acknowledge that mistakes will happen
- Include “Us” (e.g., System) issues,
Not just “You” (e.g., training) issues
- Make safety a middle management metric
 - Engage labor early
 - Include the *System* --
manufacturers, operators, regulator(s), and others
- Encourage and facilitate reporting
 - Provide *feedback*
 - Provide adequate *resources*
 - *Follow through* with action

How The Regulator Can Help

- Emphasize the importance of System issues *in addition to* (not instead of) worker issues
 - Encourage and participate in industry-wide “System Think”
- Facilitate collection and analysis of information
 - Clarify and announce *policies for protecting information and those who provide it*
 - Encourage other industry participants to do the same
- Recognize that *compliance* is very important, but the *mission is reducing systemic risk*

Conclusions

- ***Safety issues in complex systems usually involve human/system interface issues***
- ***Collaboration can help address not only the human performance issues but also the system issues***
- ***Collaboration can also help ensure that safety improvement programs also improve productivity, which makes the safety improvements more sustainable***
- ***Aviation industry collaboration success is transferable to other industries and to workplace safety***



Thank You!!!



Questions?